MISSOURI
DIVISION OF MEDICAL SERVICES

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AMBULATORY SURGICAL CENTER (ASC) BULLETIN

Provider Bulletin News: Due to budget constraints, paper copies of bulletins are no longer distributed by DMS. Bulletins are now available only at the DMS Website address www.dss.mo.gov/dms. Please note new website address.

Bulletins will remain on this site only until incorporated into the provider manuals as appropriate, then deleted.

Missouri Medicaid News: Missouri Medicaid providers may sign-up to receive automatic notifications of all bulletins and other official Missouri Medicaid communications via e-mail. Providers and other interested parties are urged to go to the DMS website to subscribe to the e-mail list.

Table of Contents **Page**

MC+ MANAGED CARE

The information contained in this bulletin applies to coverage by the MC+ fee-for-service and Medicaid fee-for-service programs. The MC+ fee-for-service and Medicaid fee-for-service programs also provide coverage for those services carved out of the MC+ Managed Care benefit for MC+ Managed Care enrollees. Questions regarding services included in the MC+ Managed Care benefit should be directed to the enrollee's MC+ Managed Care health plan. Please check the patient's eligibility status prior to delivering a service.

HEALTH CARE PROCEDURE CODING SYSTEM (HCPCS) MODIFIER SG

Providers were notified in Ambulatory Surgical Center [ASC] and Birthing Center Bulletin Volume 26, Number 1, dated October 7, 2003, that type of service would no longer be a valid code set effective October 16, 2003. Claims submitted to Missouri Medicaid by ASCs must reflect the HCPCS modifier **SG** (Ambulatory surgical center [ASC] facility service) with the appropriate procedure code.

DENTAL SERVICES PROVIDED IN AN ASC FACILITY

In order to comply with the HIPAA national standards for transactions and code sets, all Missouri Medicaid-specific procedure codes/modifiers must be replaced. The following sections of this bulletin provide procedure codes changes for dental services provided in an ASC.

PROCEDURE CODES Y6057, Y6058, AND Y6059

Effective for dates of service January 1, 2004 and after, procedure codes Y6057, Y6058, and Y6059 will no longer be valid codes for billing the facility charge for tooth extractions performed in the ASC. Please refer to the table below for replacement codes. The replacement codes will be reimbursed at the same rate as the obsolete codes.

Deleted Code	Description	Replacement Code	Description	Maximum Allowable Amount
Y6057	Tooth Extraction (1 or 2 teeth)	D7140SG	Extraction, erupted tooth or exposed root (elevation and/or forceps removal)	$290.00
Y6058	Tooth Extraction (3 or 4 teeth)	D7140SG	Extraction, erupted tooth or exposed root (elevation and/or forceps removal)	$415.00
Y6059	Tooth Extraction (5 or more teeth)	D7140SG	Extraction, erupted tooth or exposed root (elevation and/or forceps removal)	$515.00

Reimbursement for the facility charge for tooth extractions is based upon the number of teeth extracted. Providers must enter the **number of teeth** in the units field of the claim form. Failure to do so will result in claim denial.

PROCEDURE CODE Y6060

Effective for dates of service January 1, 2004 and after, procedure code Y6060 will no longer be a valid code for billing the facility charge for removal of a wisdom tooth/impacted tooth. Please refer to the table below for replacement codes. The replacement codes will be reimbursed at the same rate as the obsolete code.

Deleted Code	Description	Replacement Code	Description	Maximum Allowable Amount
Y6060	Removal of wisdom tooth/impacted tooth	D7210SG	Surgical removal of erupted tooth requiring elevation of mucoperiosteal flap and removal of bone and/or section of tooth	$490.00
		D7220SG	Removal of impacted tooth - soft tissue	$490.00
		D7230SG	Removal of impacted tooth - partially bony	$490.00
		D7240SG	Removal of impacted tooth - completely bony	$490.00
		D7241SG	Removal of impacted tooth - completely bony, with unusual surgical complications	$490.00

The maximum quantity for the procedure codes listed above is 1 (one). Multiple removals of wisdom/impacted teeth must be billed with a **quantity of 1** on separate lines of the claim form.

PEDODONTIC RESTORATIONS

Effective for dates of service January 1, 2004 and after, procedure codes M0050 - M0054W3 will no longer be valid codes for billing the facility charge for pedodontic restorations. Please refer to the table below for replacement codes. The replacement codes will be reimbursed at the same rate as the obsolete codes.

Deleted Code	Description	Replacement Code	Description	Maximum Allowable Amount
M0050	Pedodontic restoration (0 - 30 minutes)	D9999SG	Unspecified adjunctive procedure, by report	$275.00
M0051	Pedodontic restoration (31 - 60 minutes)	D9999SG	Unspecified adjunctive procedure, by report	$375.00
M0052	Pedodontic restoration (61 - 90 minutes)	D9999SG	Unspecified adjunctive procedure, by report	$450.00
M0053	Pedodontic restoration (91 - 120 minutes)	D9999SG	Unspecified adjunctive procedure, by report	$525.00
M0054	Pedodontic restoration (121 - 150 minutes)	D9999SG	Unspecified adjunctive procedure, by report	$525.00
M0054W3	Pedodontic restoration (over 150 minutes)	D9999SG	Unspecified adjunctive procedure, by report	$525.00

Reimbursement for the facility charge for pedodontic restorations is based upon the time involved in the restoration. Providers must enter the **number of minutes** in the units field of the claim form. Failure to do so will result in claim denial.

PROCEDURE CODE 21365

Ambulatory Surgical Center (ASC) Bulletin Volume 25, Number 2, dated June 13, 2003 contained additions to and deletions from the current list of Medicaid covered ASC codes based on Medicare's list of approved ASC procedures. Procedure code 21365 has been identified by the Centers for Medicare and Medicaid Services (CMS) as a deletion from the list of Medicare approved ASC procedures and will no longer be covered by Missouri Medicaid in the ASC setting effective for dates of service January 1, 2004 and after.

Provider Communications

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